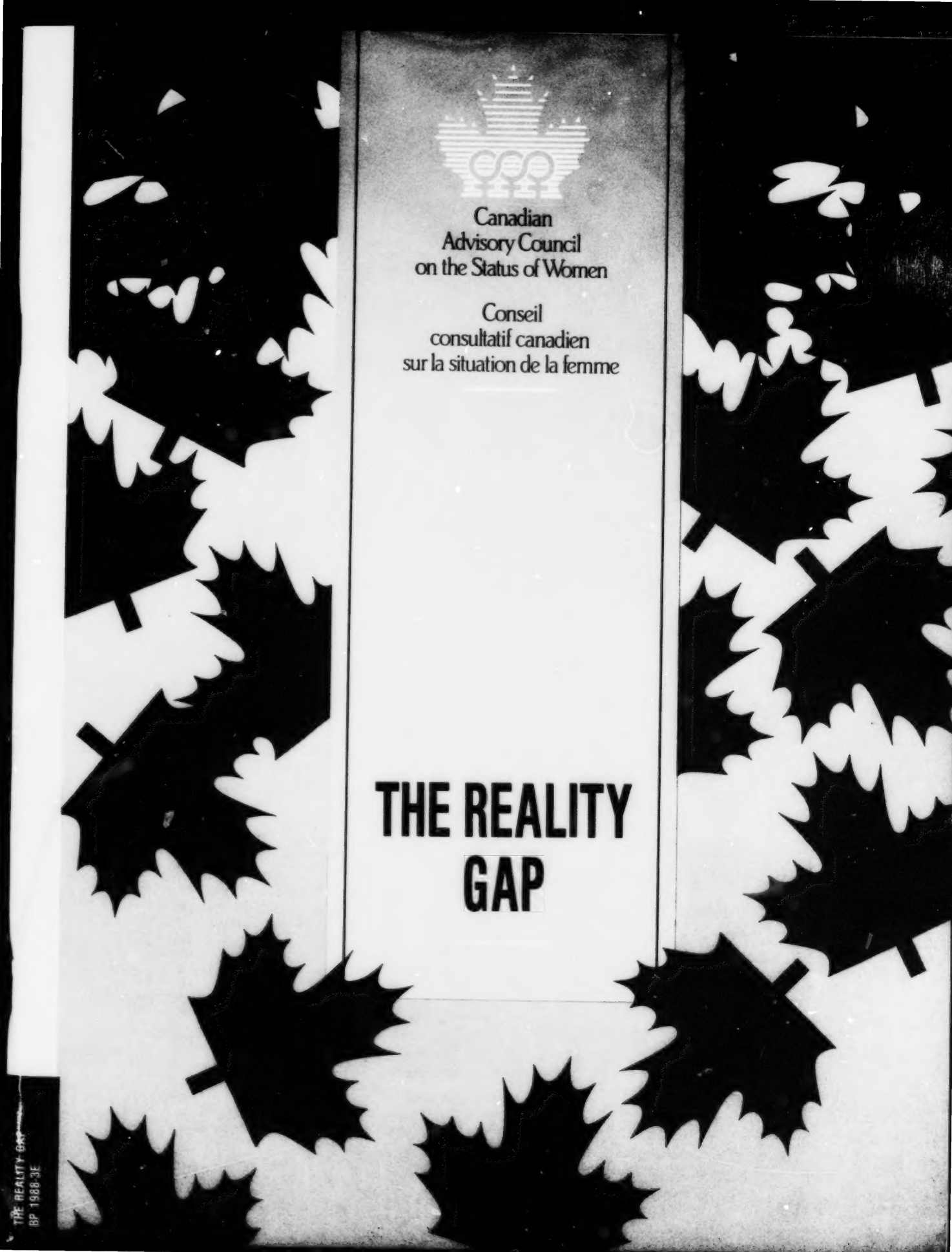

Canadian
Advisory Council
on the Status of Women

Conseil
consultatif canadien
sur la situation de la femme

THE REALITY GAP

THE REALITY GAP
BP 1988-3E

89-04121/

BACKGROUND PAPER

THE REALITY GAP:
CLOSING THE GAP BETWEEN WOMEN'S NEEDS AND AVAILABLE PROGRAMS AND SERVICES

by Sherri Torjman

April 1988

Canadian Advisory Council on the Status of Women

Prepared for the
Canadian Advisory Council on the Status of Women
P.O. Box 1541, Station B
Ottawa, Ontario
K1P 5R5

Background papers are prepared to inform Council members, the general public, and parliamentarians on issues being considered by the Council. They are designed to provide an initial analysis on a subject and to generate public discussion. The information contained in this background paper was provided by the author, and does not necessarily reflect the views of the Council.

Cette publication existe en français sous le titre *L'écart des réalités : combler l'écart entre les besoins des femmes et les programmes et services offerts.*

TABLE OF CONTENTS

EXECUTIVE SUMMARY i

THE PROBLEM 1

- Our Reality 1
- Our Needs 3
- The Reality Gap 3

SOME CAUSES OF THE PROBLEM 4

- The Residual Mould 4
- A "Mixed Market" Approach 5
- Male Dominance of Program/Policy 6

SOME EXAMPLES OF THE PROBLEM 8

- Program Gaps 8
  - Income Security 8
  - Child Care 13
  - Independent Living Services 15
- Program Gaps: Summary 17
- Delivery Gaps 17
  - The Piecework Approach 18
  - Lack of Coordination 20
  - "Casualty" Orientation 23
  - "Cracks" in the System 25
  - Inappropriate Services 27
  - Lack of Control Over Services 28
- Delivery Gaps: Summary 30
- Double Gaps 31
  - Rural Women 31
  - Aboriginal Women 32
  - Immigrant Women 34
  - Visible Minority Women 36
  - Disabled Women 39
  - Adolescent Women 40
- Double Gaps: Summary 41

ADDRESSING THE PROBLEM 41

- Bridging the Gap 41
  - Articulating Need 42
  - Challenging Policies 44
  - Changing Institutions 46
  - Becoming More Involved in Decision-making Processes 51

ELIMINATING THE GAP? 52

NOTES 53

SELECTED BIBLIOGRAPHY 57

EXECUTIVE SUMMARY

This background paper is about the "reality gap" — that is, the distance between women's real-life needs and the social welfare programs and services that currently exist to meet those needs.

The paper describes some of the major reasons for the reality gap. First, because services are provided under a variety of auspices, there are problems of coordination as well as unevenness in the availability and quality of these services throughout the country.

A second major reason for the gap is the "residual" orientation which has shaped the evolution of these services. Most existing services are geared toward "after-the-fact" intervention when a crisis has occurred. There are few community supports which provide, for example, respite child care, preventive health care, or assistance to women who need help to leave situations of potential violence.

A third major factor which has helped create a reality gap for women is the male dominance of social policy and of public decision-making processes. Because the male experience is different from the reality experienced by women, the priorities established by men are often unresponsive or inappropriate to the needs of women. Men have also dominated certain program areas, notably the fields of health and mental health. This reality has had an enormous influence upon the kinds of services that have evolved in these areas.

Collectively, these factors have resulted in three major types of gap: program gaps, delivery gaps, and double gaps or gaps with respect to particular groups of women. Examples of each of these gaps is provided in this background paper.

Three major program gaps in the areas of income security, child care, and independent living services are discussed. Six types of delivery gaps are described: the piecework approach, lack of coordination, the "casualty"

orientation, "cracks" in the system, inappropriate services, and lack of control over the services provided. The section on double gaps addresses the needs of the following major groups of women: rural women, aboriginal women, immigrant women, visible minority women, disabled women, and adolescent women.

In all cases, the examples provided are illustrative of the problem and are by no means intended to provide an exhaustive description.

Means of addressing the problem are discussed in the section on "Bridging the Gap". Four major kinds of action are suggested to help bridge the reality gap. These actions include articulating need, challenging inappropriate policies, changing institutions, and becoming more involved in decision-making processes.

The paper concludes that it may not be possible to eliminate the reality gap; there may always be a lag between the existence of certain needs and the availability of appropriate services to meet those needs. Women's groups and organizations can play a key role, however, in bridging the gap so that the distance between our real-life needs and the corresponding programs and services can be narrowed.

THE PROBLEM

Our Reality

In their daily lives, most women experience a "reality gap" — that is, the distance between their needs and the programs and services that currently exist to meet those needs.

Women share a common reality. Despite our differences, our unique needs, and our individual preferences, we are the same in one important respect. Collectively, we are still the caregivers in families, in communities, and in society.

In the past decade, women have made major advances in various educational and occupational fields. In particular, we have taken significant strides in the paid labour force. But when we tally up our progress, we realize that we have not made much headway at all in one important area. We have not moved beyond the societal expectation of **women** bearing the primary responsibility for caregiving.[1] It is primarily women who remain the social workers, child-care workers, and nurses in society.

Despite all the other roles and responsibilities we have assumed in recent years, it is still women who spend the most time caring for and raising children. It is the daughters and sisters who look after sick and elderly parents in most families.

There is nothing wrong with women's participation in caregiving. Yet the entrenched and seemingly intransigent expectation that women continue to assume **all** caregiving responsibilities has had serious psychological, economic, and social repercussions. The enforced caregiving role has meant that we as women face unique stresses: the physical strains of housework, the mental exhaustion and loneliness of childrearing, and the juggling of endless tasks and demands.

Our caregiving role is not only physically and mentally stressful in a personal sense; in a broader societal context, it has held us back collectively from achieving economic equality. We become visible as workers only when we do "real" work for wages outside the home; this, despite the fact that we work long hours in the home on activities related to the care of others.

In recent years, women have become increasingly active in the paid labour market. In 1986, 56 per cent of women with children under age three were participating in the labour force. This compares with 32 per cent in 1976. The labour force participation rate of women with children between the ages of three and five increased from 41 per cent to 62 per cent over the same ten-year period. The rate for women with children between the ages of six and 15 increased significantly as well, from 50 per cent to 68 per cent between 1976 and 1986.[2]

Even when we are involved in the paid labour market, our efforts are not adequately compensated. We continue to be viewed not as breadwinners in our own right but as secondary earners whose wages supplement those of a primary earner.

Large differentials exist between the wages earned by men and those earned by women. In 1986, the latest year for which data are available, average earnings for all full-time female workers were $19,874.[3] This amount represents 65.9 per cent of the earnings of male full-time workers — $30,131 in that year.[4]

This, then, is our reality: physical and mental stresses different from those experienced by men, a secondary economic role, and the continued sublimation of our own needs. In order to change our reality, we need not give up nurturing, caring, and taking responsibility for others. But what we must do, within the confines of our caregiving, is take greater control of our own lives. We must begin by making society conform to **our** needs rather than continually moulding, shaping, and accommodating our needs to meet the demands of society.

Our Needs

We all have needs that are essential to basic living. These include needs for physical safety and well-being such as income security, adequate housing, health care, and protection from physical violence. In addition, we have psychological needs for emotional fulfilment and recognition of our worth and value.[5]

We strive constantly to satisfy these needs and we do so primarily through our own capacities, skills, and resources. To a large extent, however, our physical and psychological needs remain unmet. Our incomes are lower and more unstable than those of men. Much of the caregiving work performed by women is both unpaid and little acknowledged or appreciated, with the result that a large part of women's lives is significantly devalued. One in ten women is a victim of violence[6] and yet our needs for physical security are not being adequately addressed.

If we are to meet our needs, most of us must at some point in our lives supplement our own personal resources. We often turn to social welfare programs and services to help provide support or assistance. In fact, programs and services have been established to respond to needs in areas such as income security; employment, training, and education; housing; physical and mental health; protection from domestic violence; child care; marital counselling and family supports; and independent living services.

The Reality Gap

It is at the point when many of us turn to these programs and services to assist us that we experience a "reality gap". Something is missing. There is a space or distance between our real-life needs and the programs and services that currently exist to meet those needs.

SOME CAUSES OF THE PROBLEM

Several factors have played a role in creating and sustaining the reality gap. These factors include the "residual" mould in which the evolution of social welfare programs and services has been cast, a mixed market approach to the development and delivery of social welfare services, and men's traditional domination of certain program areas as well as the arenas where key decisions in the social policy field are made.

The Residual Mould

The first major factor explaining the presence of gaps is that the historical evolution of social welfare has been cast in the "residual mould".[7] This means that individuals are expected to care for themselves primarily through their own resources, with the support of their families, and through the private market. Social welfare programs and services come into play only when individuals are unable to meet their needs through their own resources. These persons then become "in need" or "likely to be in need" of assistance.

The residual model of social welfare contrasts with the institutional model. The latter views risks to health and well-being as one of the inevitable costs of economic growth and progress in modern society and holds that these risks should not be borne solely by the individual.[8] Within this institutional model, society has a responsibility to promote the "public good", to anticipate and minimize potential risks and hazards.

It is important to note that, although Canada has an institutional mode of funding its health-care services, the delivery of these services is still primarily residual in nature. As a result of this orientation in the social welfare field in general, services have developed in a piecemeal fashion rather than in a well-planned and comprehensive manner.

A "Mixed Market" Approach

Shared responsibility means that many players are involved in the provision of health and social programs and services. Public, voluntary, and private agencies all play a role. At the public level alone, federal, provincial, regional, and municipal governments are involved in varying degrees in the social welfare field.

Diversity of auspice is a reality that has resulted from the residual orientation. This diversity is also part of our historical legacy. As far back as the 1700s, local parishes in this country (primarily in Nova Scotia and New Brunswick) assumed major responsibility for providing cash and the necessities of life to needy people.[9] These parishes acted as the equivalents of modern-day municipal governments which continue today, in several provinces, to administer various social programs and services including income assistance, employment training, and child-care subsidies.

The *British North America Act* (now the *Constitution Act of 1867*) had a major impact upon the evolution of social welfare in this country. Although it did not explicitly allocate social welfare responsibility either to the federal or provincial governments, over time, responsibility devolved to the provinces because the Act referred to charitable matters and institutions as falling under provincial jurisdiction.

World War I caused the federal government to assume a greater social welfare role, especially for the dependent families of veterans and for basic public health services. Municipalities, however, remained primarily responsible for social welfare until the Depression of the 1930s.

Although today provinces are the major providers of health and social services, the federal government maintains an important involvement by virtue of its financial contributions. These are made through direct assistance to individuals (Old Age Security, Family Allowance) and through cost-sharing with the provinces under the Canada Assistance Plan (social welfare services)

and the *Established Programs Financing Act* (health services and post-secondary education).

Although governments' involvement in the health and social service fields greatly expanded throughout the 1900s, the voluntary sector assumed responsibility for many different types of programs and services. The voluntary sector includes religious organizations, non-profit associations, and service clubs. Historically, voluntary activity has been generated in response to certain needs which were not being addressed adequately by the state.

Private services refer either to non-profit agencies such as church-run child-care centres or to for-profit private companies which have become increasingly involved in the provision of services, such as nursing home care, hospital administration, child care, and detoxification programs, on a fee-for-service basis.

Shared responsibility has resulted in a "mixed market" approach to the provision of health and social services. This approach has been responsible for causing many of the gaps in program and service delivery. Specific examples of these gaps are discussed more fully below.

Male Dominance of Program/Policy

A third major factor which has been responsible for creating gaps in services is the male domination of key program areas and of the processes whereby critical decisions with respect to policy and allocation of funds are made.

In program areas, men have traditionally controlled the fields of health and mental health. Most mental health care professionals, for example, have been and continue to be male, although more women than men are treated by such professionals.[10] Training in psychiatry, considered the most "powerful" of the mental health professions, is very conservative. The focus is primarily upon intrapsychic pathology rather than on the impact that socio-economic

conditions might have upon mental well-being. Women, in particular, live under particularly stressful conditions including income "insecurity", threats or acts of abuse and sexual harassment, little respite from caregiving responsibilities, and lack of recognition of work and our worth. Yet these factors are not given adequate attention.

Males have also dominated public decision-making processes. While many more women are now entering political and administrative spheres, we still have a long way to go to close this "gender gap". In October 1987, for example, only 29 out of 282 federally elected politicians were female. This means that women comprise only 10 per cent of the "House" — a percentage which is clearly disproportionate to the population breakdown in this country.

This representational gap is a key factor in explaining why certain services, such as shelters for battered women, remain chronically underfunded. In some cases, men do not see the need for such services as real or important.

Female politicians can bring to public decision-making processes their life experience as women and their ability to relate to women as potential or actual consumers of social services. As working women, for example, they likely will have experienced the difficulty of trying to obtain high-quality, reliable, and affordable child care.

They understand the employment-related stresses that women face in the workplace. While they are working and possibly caring for their own children, they may also be looking after sick or elderly parents. They themselves might be the victims of family violence.

In short, these women may have personally faced many reality gaps. This means that women bring to the public sphere an important perspective that can help influence the content of the public agenda as well as priority and funding decisions. The current reality is that many issues of importance to women do not make their way onto the public agenda.

In summary, the residual orientation, the mixed market approach, and male dominance of program and policy areas have collectively influenced today's health and social programs and services. While these are not the only factors at play, they are key to explaining many of the gaps that currently exist.

Three major types of gap will be discussed in this paper: gaps in program, gaps in delivery, and double gaps with respect to particular clientele. Each area of gap is described more fully in the next section. It should be noted that, in this background paper, it was not possible to address all the areas where gaps exist. The examples provided are intended to be illustrative rather than exhaustive; every woman reading this paper can probably tell her own story about the gaps she has personally encountered. Unfortunately, there is no lack of examples.

SOME EXAMPLES OF THE PROBLEM

Program Gaps

■ Income Security

Women experience a chronic state of income "insecurity" and are more likely than men to be poor. The National Council of Welfare reports that more than half (56.7 per cent) of all low-income Canadians are female. In 1985, six in ten or 60.4 per cent of single-parent families headed by women were poor.[11]

This poverty is due to several factors, including the large wage differentials cited earlier, the inadequate enforcement of maintenance and child custody payments, and gaps in income security programs. The gaps in two of these programs — the Canada/Quebec Pension Plan (C/QPP) and social assistance — will be examined here.

■ *Canada/Quebec Pension Plan*

Two major public plans provide pension benefits to elderly Canadians. The Old Age Security pension is received by every Canadian over the age of 65 who meets the residence requirements. As of July 1987, the value of the pension was $303.64 per month. Old Age Security recipients in need are entitled to a Guaranteed Income Supplement over and above the basic pension. The maximum supplement is $360.87 per month for a single person and $235.03 per month for each spouse in a married couple. Thus, a married person receiving the maximum supplement would receive a total of $538.67 ($303.64 plus $235.03) and a single person would receive a total of $664.51 ($303.64 plus $360.87).

The second layer of income support for elderly Canadians is the Canada Pension Plan which provides benefits to individuals who have participated in the paid labour force. The Quebec Pension Plan offers similar coverage in Quebec.

Under the C/QPP, workers are expected to contribute 1.9 per cent of their earnings over a minimum amount (now $2,500 per year) up to a maximum amount (now $25,900 per year). Employers match these contributions. Self-employed Canadians contribute both the employer and employee share — or 3.8 per cent of their earnings — to the C/QPP. Although the C/QPP provides benefits to the spouses of deceased contributors, disability benefits, lump-sum death benefits, and orphans' benefits, only the retirement benefit will be discussed here.

There are a number of gaps in the C/QPP which have a particularly severe impact upon women. The first problem is that many women are not even covered by the Plan. Homemakers' non-waged labour pays them no earnings from which they can make contributions. Part-time workers with earnings lower than the minimum exemption are also excluded.

A second major gap is that those women who are actually eligible to participate in C/QPP receive lower benefits than men. This is because the amount of benefits received is based upon wages and years of attachment to the paid labour force. In comparison to men, women have earned lower wages

and have had fewer years of uninterrupted paid employment. In December 1986, the average monthly retirement benefit for women was $189.10 compared with $293.90 for men.[12]

In that same month, almost 32 per cent of women received a retirement pension from C/QPP of less than $100.00 while only 11 per cent of men received that amount. By contrast, only ten per cent of female beneficiaries received retirement pensions of between $350.00 and $399.00 in that month while 28 per cent of male beneficiaries received that amount.[13]

■ *Social Assistance*

There are serious inadequacies in the welfare system — the income program of "last resort". Welfare recipients must survive on benefits that fall well below the poverty line. Single-parent families, the great majority of which are headed by women, comprise almost 27 per cent of the social assistance caseload in Canada.[14]

In 1986, the estimated welfare income ranged from 59 per cent to 84 per cent of the poverty line[15] (see Table 1). The figures in this table must be used with caution because they are both maximum and minimum amounts. The figures are maximum levels in that they represent the highest amount that provinces will provide for the basic needs — food, clothing, shelter, utilities, and personal allowances — of single-parent families with one child. They are also minimum amounts, however, in that they do not include any of the special needs allowances, such as health or work-related expenses, to which these families may be entitled. These allowances are discretionary and are provided according to the judgement of individual welfare workers. Neither do the amounts indicated in the table incorporate any of the benefits "in kind", such as public housing or child-care subsidies, to which single-parent families may have access.

The rates in Table 1 were calculated on the assumption that recipients have no outside income other than federal child benefits and provincial tax credits where relevant. The shelter allowances incorporated in these rates assume that recipients are tenants and are not homeowners or boarders.

TABLE 1 ESTIMATED WELFARE INCOME BY PROVINCE, SINGLE-PARENT FAMILY, ONE CHILD, AGED TWO

	Social Assistance	Additional Benefits	Family Allowance	Child Tax Credit	Provincial Tax Credits	Total Annual Income	Poverty Line	Poverty Gap	Total Welfare Income as % of Poverty Line
Newfoundland	8,496	--	379	684	--	9,559	13,340	-3,781	71.7
Prince Edward Island	8,676	--	379	684	--	9,739	11,548	-1,809	84.3
Nova Scotia	8,011	--	379	684	--	9,074	13,340	-4,266	68.0
New Brunswick	6,848	--	379	684	--	7,911	13,340	-5,429	59.3
Quebec	7,428	300[a]	341[b]	684	348[c]	9,101	14,055	-4,954	64.8
Ontario	8,756	80[d]	379	684	350[e]	10,249	14,055	-3,806	72.9
Manitoba	7,111	--	379	684	751[f]	8,925	14,055	-5,130	63.5
Saskatchewan	8,741[g]	--	379	684	--	9,804	13,340	-3,536	73.5
Alberta	8,418	--	300[h]	684	458[i]	9,860	14,055	-4,195	70.2
British Columbia	7,728	70[j]	379	684	--	8,861	14,055	-5,194	63.0
Yukon[k]	9,192	48	379	684	--	10,303			
Northwest Territories[l]									

Source: Adapted from National Council of Welfare, **Welfare in Canada: The Tangled Safety Net** (Ottawa: November 1987), pp. 65-72.

Notes:

a. This is the Quebec Availability Allowance. Families with children under the age of six are entitled to claim either the Child Care Expense Deduction or an Availability Allowance worth $300.00 for the first child, $200.00 for the second child, and $100.00 for the third and subsequent children.

b. Quebec has its own rates of Family Allowance.

c. This is the Quebec Property Tax Credit.

d. This amount represents the winter clothing allowance provided to families with children.

e. This figure represents the combined amount of the Sales Tax Credit and Property Tax Credit.

f. This is the combined amount of the Property Tax Credit and Cost of Living Tax Credit.

g. Saskatchewan is the only province that deducts the Family Allowance from social assistance income.

h. Alberta has its own rates of Family Allowance.

i. This is the Renter Assistance Credit.

j. British Columbia provides a Christmas Allowance.

k. Poverty line comparisons for the Yukon are not provided because the Statistics Canada low income cut-offs do not take into account the high basic living costs north of the 60th parallel.

l. Rates for the Northwest Territories have not been included because it was not possible to obtain average cost estimates for shelter rates in Yellowknife.

A recent Alberta study documented the testimony of welfare recipients who graphically described the realities of life on welfare. It is, in their words, a "no-frills flight".[16] The recipients identify many glaring gaps in this income support program. Fifty-three per cent of individuals surveyed indicated that they had to pay more than the maximum allowed for shelter and utilities. Only 50 per cent of respondents stated that they received money for school supplies even though these are supposed to be included in a school allowance cheque paid at the beginning of the school term.

Sixty per cent stated that inadequate clothing for their children was a problem. The stringent budgets of welfare recipients do not allow for major purchases such as warm winter clothing.

Seventy per cent of recipients who had children and were looking for work said that they did not receive money for child care. Only 55 per cent of respondents received an allowance for transportation even though it is available to individuals looking for work or enrolled in a training program. Forty-nine per cent of recipients interviewed had asked for additional funds for work-related clothing; only half had their request granted, even though the welfare department permits such an expenditure.

Although this survey was conducted in Alberta, welfare systems throughout the country are riddled with similar gaps and inadequacies.[17] This is of major concern because welfare is the principal means of financial support for almost two million Canadians.[18]

It is sometimes difficult for recipients to get off welfare because many of the policies and practices themselves act as disincentives to work. Often, individuals who are on welfare and are seeking employment do not receive the benefits when searching for a job.

Recipients seeking employment are frequently discouraged by high "tax-back" rates on earned income. This is the amount by which provinces reduce welfare cheques when recipients work. After paying for child care, transportation, clothing, and other work-related expenses, welfare recipients are

often not much further ahead than if they had simply remained on the welfare rolls.

■ Child Care

Whether women work inside and/or outside the home, we need child-care services for both our economic security and our mental well-being. Yet there are large gaps between our need for child care and the services currently in place to meet this need. The large growth in female labour force participation rates has not been matched by a corresponding increase in services. Although there has been an expansion of the licensed child-care system in Canada, the number of licensed spaces is still insufficient to meet the demand. In 1986, there were 202,498 children under the age of 18 months likely to require non-parental child-care arrangements. However, only 13,969 licensed spaces were available for this age group. In other words, only seven per cent of infants were cared for in the licensed system.[19]

There were 198,000 toddlers between the ages of 18 and 35 months who were likely to require some form of non-parental care arrangement in 1986. Yet only 27,605 licensed spaces were available in this country for children of that age group. Only 14 per cent of those children who might have used a licensed child-care space were, in fact, served.[20]

A total of 397,311 children between the ages of three and five were likely to use some form of non-parental care arrangement in 1986. But only 34 per cent or 134,826 children were served by the licensed system.[21]

These figures indicate the serious shortages in the availability of licensed child-care spaces. In addition to the supply problem, there are gaps in existing services. For example, these services tend to respond primarily to the schedule of women employed on a full-time, "nine-to-five" basis. Most services do not address the needs of those women who work part-time or irregular hours. As well, few licensed child-care programs offer occasional

services giving women a break from the constant demands of work inside and outside the home.

From the perspective of the existing services, these gaps are understandable. Child-care services experience severe financial pressures. They are faced with the difficult task of providing high-quality care with minimal budgets. Most child-care centres operate at a deficit. It is the child-care workers who subsidize the services through their minimum wage salaries. These caregivers are primarily women whose work is greatly undervalued; they are paid low wages because they are doing a job which has traditionally been done by women for "free".

Gaps with respect to child care for school-aged children are equally serious. Almost 360,000 or 14.5 per cent of children between the ages of six and twelve are latch-key children. That is, they care for themselves before or after school hours or are cared for by a minor sibling. While this figure is an approximation, it is likely to be an underestimate as many parents are reluctant to admit that they must leave their young children unsupervised.[22]

There are few licensed child-care spaces for school-aged children. In 1986, only 44,117 licensed school-aged spaces existed throughout the country. Although this number represents a substantial increase over 1979, when there were only 7,000 licensed spaces, the current situation is inadequate when the number of licensed spaces (44,117) is compared to the estimated number of latch-key children (360,000).[23]

Figures with respect to the demand for and supply of child care must be used with caution. Some families do not need licensed services; they prefer to make their own arrangements with relatives, friends, or neighbours. Other families send their children to nursery schools, cooperative play groups, kindergarten or, in the case of school-age children, clubs.

While some families choose not to use the licensed child-care system, many families make informal arrangements precisely **because** nothing else is available or affordable in their communities. The use of informal child-care

arrangements must be viewed partly as a function of individual preference and partly as a function of a lack of suitable alternatives.

Informal child-care arrangements work very well for some families and may be best suited to individual children's and parents' needs. At the same time, however, serious concerns have been raised about the quality of informal child care — particularly with respect to the competence of the care-giver and the adequacy of the "program".[24]

Increasing the number of licensed child-care spaces would represent a significant step in narrowing the reality gap for women. But growth in the number of spaces alone is not sufficient to close this gap. A variety of high-quality, supervised, licensed, flexible services is required to respond adequately to women's wide range of child-care needs. There are few emergency child-care services in hospitals or community centres in the event of sudden illness or hospitalization of the caregiver. Finally, there is a lack of licensed services to meet the needs of disabled preschool children. This gap places a great burden upon mothers who are usually the ones to stay home and provide full-time care without respite.

■ Independent Living Services

Independent living services refer to a package or group of services that help disabled persons live free from continued dependence on institutions or family members. These services often combine a group housing arrangement with built-in supports that foster independence, such as employment counselling or transportation. Concrete assistance with cleaning and shopping may also be provided. Models of such an approach are the Fokus Housing project for physically disabled persons in Winnipeg and the group homes established by the Mental Patients' Association in Vancouver.[25]

The major gap with respect to these services is simply that there are far too few such programs in Canada. While the precise extent of need is unclear, there are significant numbers of disabled persons in Canada. A 1986

profile found that almost 13 per cent of Canadians — or 2,448,000 persons aged 15 and over — report one or more disabilities.[26] This number excludes those individuals with any form of mental or learning disability. Neither does it include those individuals currently living in institutions.

The report also devised a classification to determine the extent of disability. According to the classification employed, 54 per cent of disabled persons are mildly disabled, 23 per cent are moderately disabled, and 14 per cent are severely disabled.[27] Forty-six per cent of physically disabled adults reported that they require personal assistance for one or more daily living tasks. An additional 16 per cent need assistance for some activities.[28]

Lack of community supports has also affected persons with mental disabilities. The "push" toward deinstitutionalization of mentally disabled individuals has occurred without adequate community supports in place. There are neither sufficient nor appropriate networks of services to support independent living in local communities.

One of the reasons for the slow growth of such systems is that the funding arrangements for packages of community-based services are complex. Although institutional funding is derived primarily from one source (provincial ministries or departments of health or of social services), packages of services provided in local communities are supported through diverse funding sources (provincial ministries or departments of health, social services, housing, and income security).

Voluntary organizations which try to establish independent living services in local communities are often thwarted in their efforts by the funding complexities. For example, government departments are generally unwilling to allocate funds to a project such as a group home until the commitment of the other relevant government departments has been obtained. The latter will not provide funds until they are reassured of the formers' commitment. This "catch-22" situation has been a major stumbling block in the establishment of community-based service networks.

The lack of independent living services has meant that many disabled adults must continue to live at home with their families. This places great financial, physical, and emotional demands upon aging parents who worry about their continued ability to care for their child, especially if they themselves become ill or if they die before their child is independently established.

Currently, very few programs match severely disabled individuals with caregiving families to provide a break for the natural parents. Mothers, in particular, bear the brunt of the endless caregiving responsibility because they are the ones who tend to stay home with the disabled child. There is little opportunity for physical or mental relief.

Program Gaps: Summary

Program gaps in relation to the needs of women have been described in three major areas: income security (the Canada/Quebec Pension Plan and social assistance), child care, and independent living services. The gaps described in these three areas of service are examples only. As previously indicated, gaps exist in virtually all social welfare programs and services.

Delivery Gaps

Many of the program gaps described in the previous section could be bridged through improved funding of these programs or services. Yet many well-funded programs and services already in place are still not meeting women's needs. In these cases, there are problems with the delivery of these services which will not necessarily be resolved with additional funds. What is required are modifications to the manner in which these programs and services are provided in order to make them more responsive to real-life needs. Six major types of delivery gap are described below.

The Piecework Approach

Even though human needs are constantly changing, the programs and services that have been established to meet these needs are designed as if our needs and lives were compartmentalized into neat, separate categories. They take little account of the fact that the places in which we live have a significant impact upon our health, that worries about income security have an important influence on mental health, and that educational training and upgrading programs for women must consider our child-care needs.

Existing services tend to deal only with the individual component of need they have been set up to address. Yet people often have multiple needs. An unemployed single-parent mother, for example, might require help in obtaining social assistance, in finding a job, in locating suitable housing, and in arranging suitable child care.

This woman will likely soon find out that she must become her own advocate — pulling together the resources from disparate agencies into a package of appropriate services. The individual pieces of the puzzle are not delivered in any comprehensive fashion to ensure that the separate parts are responding in an aggregate way to real-life needs. Few community-based centres offer services in a range of areas including income assistance, housing, and employment. There is simply no "one-stop shopping" in the social welfare field.

Nowhere is the piecework approach more evident than in the delivery of health-care services. Patients are often treated as though they were comprised of nuts, bolts, and other mechanical parts. The piecework orientation is reinforced by a funding system which reimburses doctors, in particular, on the basis of the single, technical activities performed on our individual parts. The exception is the province of Quebec which has attempted to combine the delivery of health and social services in local community service centres, called "centres locaux de services communautaires".

While Canadians have universal access to health care, the services themselves are often inappropriate in their orientation because they are predominantly "casualty-oriented" (see below). The current health-care system does not reward the teaching or practice of preventive health care. Neither does it adequately address how factors such as income insecurity, poor housing, and medical problems can adversely affect health and well-being.

The piecework approach results in a network or "labyrinth" of programs and services through which potential users must wend their way. One mother's feelings of being lost in the labyrinth are illustrated by the quote below in which she describes her attempt to find services for her mentally handicapped child. The quote is excerpted from a documentary film produced in 1986 about the Community Living Society, a Vancouver-based organization formed by a group of parents of severely disabled children. These parents could no longer tolerate the "runaround" they were being given by traditional agencies and developed a unique and effective response to challenge the piecework approach. (This response is described more fully in the section on "Bridging the Gap".)

> We discovered that we had all been sent down different tunnels just to be sent back again. We would call somebody who was supposed to be the support authority in the community and we'd say: "This is our need." And they'd say: "You're in the wrong place but if you go over to that person and go down that tunnel or go to those services you'll be fine." So you go to that service and you go down another tunnel and there is nothing at the end again. They'd send you to another desk or another office over and over again until finally you had exhausted all the desks or all the tunnels and before you knew it you were standing there by yourself with your son or daughter. And there was nobody that you could turn to. I can remember the day that I went to the person at the Ministry of Human Resources in B.C. who was supposed to be the ultimate authority in giving us something in terms of our son . . . only to be told there was nothing she could do. So I went home. There was nowhere else to go . . . so I just went home. And we all have that same story.[29]

■ Lack of Coordination

It was pointed out in the introduction to this paper that health and social programs and services are provided under a mixed market approach. A mixed market can be compared to a kitchen full of cooks who have no common recipe. Even when services are provided within the same auspice, problems can arise with respect to coordination.

Provincial governments, for example, are primarily responsible for the provision of health and social services. Provinces parcel these out to individual departments of health, income security, social services, housing, and employment. These departments establish policies and programs within their respective areas of jurisdiction.

The result is that these policies and programs are not always developed in tandem and are consequently inappropriate to real-life needs. Employment and training programs, for example, have often been launched without taking into account the need for child-care services. Income support programs, such as social assistance, are run independently of social housing programs. Yet locating affordable and suitable housing is one of the major problems faced by welfare recipients.

A federal interdepartmental consultation on the family, held in July 1986, found many departments involved in providing public information to promote "healthy" families. What became readily apparent was that there was no coordination among these programs to ensure that they neither duplicated nor contradicted each other.[30]

Coordination problems invariably arise when many players are involved in the provision of a particular service. One example — home health care — is provided below. It is important to note, however, that coordination is a difficulty that tends to arise when addressing all multidimensional social problems such as battered wives, child sexual abuse, and homelessness.

Home health care is an increasingly important service. Elderly Canadians have become more vocal and articulate in expressing their desire to stay out of institutions and lead normal lives in their own homes for as long as possible.

Demographic trends will create new demands for this service. The 1986 Census revealed that the number of persons aged 65 and over in Canada had doubled over the past two decades to 2.7 million. Only nine per cent, however, were living in retirement homes or institutions. More than 50 per cent of the elderly live with spouses or unmarried children and 25 per cent live alone in their own homes.

Home health care consists of a "triad" of services: nursing care, homemaker services, and medical care. Depending upon individual need, this triad may be supplemented by a variety of other services including transportation, occupational therapy and physiotherapy, personal contact services (friendly visitor, telephone crisis line), and nutrition and diet therapy.

Many gaps exist in current services. For example, the availability and comprehensiveness of these services vary widely by province. Some components of the system, particularly nursing and medical care, are better developed than other components, such as home-delivered meals and homemaker services. The latter have traditionally been provided by unpaid female caregivers — the mothers, daughters, or sisters of the sick or elderly person. No doubt, the slow growth of these services is because women have been voluntarily filling these gaps.

In addition to the availability gap, coordination is often a problem. The specific needs of any given individual are met through a "package of services" delivered under a variety of auspices. For example, physiotherapy is provided at the local hospital, nursing service may be provided by the Victorian Order of Nurses, homemaker services may be available from the municipal social services department, and "meals-on-wheels" may be prepared by a local voluntary organization.

It is important to note that each person receiving the service, or one of his/her family members, often becomes, "de facto", part of the treatment team by assuming the role of "case manager". Because these case managers are usually women, they become the persons primarily responsible for the coordination of the sick or elderly person's case. The case manager must ensure that each component of the care is provided at the correct time and in an appropriate manner.

The case manager acts as the link between the home and all the other agencies, keeping the professionals and volunteers who provide the services informed of any important developments. The case manager also has responsibility for follow-up when problems are encountered with respect to service delivery.

Yet the "de facto" case manager is often overlooked in home health-care systems. One of the major gaps in these services is that there is rarely provision made for respite care for the sick or elderly person as well as for the female caregiver providing many of the homemaking, transportation, and nurturing services. The stresses involved in caring for a sick or elderly person are compounded for many women who are at the same time caring for young children and/or earning a living themselves.

The term "sandwich generation" has been coined to describe the women who are, at the same time, the caregivers of children and the coordinators of care for sick or elderly parents. These women are pushed to the limit in terms of the physical and emotional demands placed upon them. Yet traditional services have been slow to respond to their need for a greater variety and improved delivery of home health services as well as for respite from their onerous caregiving responsibilities.

■ "Casualty" Orientation

Yet another delivery gap is that existing programs and services tend to be casualty-oriented. They come into play **after** a problem has surfaced or **after** a crisis has occurred. Some examples of targetted services are those for battered women, for individuals who have been diagnosed as mentally ill, and for families that have no income or resources.

Much less attention has focussed upon prevention. The issue of child abuse, which has generated a great deal of public concern, illustrates this point. Although systems are in place to protect children after a violent situation has occurred, parenting supports in our communities are inadequate. We have no emergency or respite child-care services; we have few support groups for parents of preschoolers.

Our health services are geared toward after-the-fact intervention. We allocate millions toward the treatment of "already sick" patients. Yet we do relatively little in the way of prevention, such as community-based screening programs for high blood pressure or programs to teach women about breast self-examination. It is possible that the federal Minister of Health and Welfare's discussion paper, *Achieving Health for All: A Framework for Health Promotion*, will encourage more activity in the health promotion and prevention fields.[31]

Nowhere is the casualty orientation more evident than in the mental health field. Mothers, in particular, can usually recognize if a family member is experiencing undue stress or appears to be on the verge of a "breakdown". Mental health organizations receive countless calls from parents asking for advice, particularly with respect to their adolescent children.

Yet mental health services are structured to intervene only when individuals are considered to be a danger to themselves or to others. While this practice safeguards the rights of individuals, it has also stood in the way of providing assistance to families at early stages when the signs and symptoms of an impending crisis become evident and when the likelihood of successful treatment is greater. There are relatively few support services, for example,

for the parents of adolescent children to help these parents anticipate or deal with some of the difficulties they may encounter.

A casualty or residual orientation may appear, at first glance, to be less costly than a preventive or more institutionally based approach. In reality, however, there are high costs associated with such after-the-fact intervention. In the case of wife battering, for example, these include not only economic but also psychological and social costs.

A major study on wife battering revealed that

> . . . battered women, after prolonged abuse, suffer from low self-esteem, they stop taking care of their appearance and health, they frequently blame themselves for the violence, and they feel overwhelming guilt. In addition, they are extremely isolated and may use alcohol and/or drugs to cope with the physical and emotional pain.[32]

Women who live under the constant terror of violence may also be forced to use violence to protect themselves or their children.[33]

The effects of domestic violence upon children were found to be equally severe. Many of these children are themselves physically, emotionally, or sexually abused. Often, girls who see their mothers battered end up as battered wives themselves because they have low self-esteem and are vulnerable to violence. As a result of their experiences, they come to believe that violence is a way of life, that men are allowed to be physically abusive, and that women must be submissive victims. Boys who grow up in violent homes are likely to have adjustment difficulties and to manifest behaviour problems. They are more likely to be violent in their own adult relationships.[34]

There are also high costs to society; in addition to the direct costs of protective services such as police and child welfare, the indirect costs of medical, social, and legal assistance in dealing with victims and abusers must be calculated. Society pays a social cost as well in the form of children who are emotionally traumatized and adults who are unable to function to their full potential.[35]

There is a great need in this country for casualty-oriented services, such as shelters to protect the victims of family violence. At the same time, however, a wide range of community supports is required to help give women the inner strength and concrete assistance they may need to deal with or leave situations of actual or potential violence.

■ "Cracks" in the System

Despite the range of services offered by the existing network of health and social programs, these services often exclude certain groups of individuals, such as severely disabled persons, the homeless, and the working poor. Some groups have multidimensional problems requiring a multifaceted response. Others do not "fit" the eligibility criteria. In both cases, existing needs are not being met.

For example, individuals with exceptionally special needs such as severely intellectually impaired persons or autistic persons tend to be institutionalized or left to the care of families. They are often "written off" as too difficult to handle given the current network of services.

Families, too, find little support or assistance in caring for these family members. Mothers of disabled children are especially vulnerable. Their onerous caregiving responsibility is often accompanied by feelings of guilt and shame in having borne a severely disabled child. Yet their mental health needs continue to go largely unrecognized as does their need for respite care.

Homeless people are another group that falls between the cracks. In a national survey conducted on January 22, 1987, the Canadian Council on Social Development (CCSD) found that 7,751 people (men, women, and children) slept in temporary or emergency shelters.[36] The CCSD contends that these figures may be serious underestimates because the homeless are a rapidly shifting population. Over the course of a year, there could be as many as 100,000 homeless Canadians.[37] The existing network of programs and services has simply not been able to address the needs of these individuals. Such individuals continue

to slip through the last resort social assistance "safety net" which was put in place precisely to help the most needy individuals in this country.

Working poor families also experience gaps with respect to the provision of assistance. These are the families whose earnings from employment, although very low, are high enough to disqualify them from eligibility for many programs.

For example, provinces provide child-care subsidies to families on the basis of their net income (except for Saskatchewan which calculates them according to gross income) up to a certain "turning point". The subsidy is reduced by a designated percentage for every dollar earned over the turning point up to a "break-even" point. It is at the break-even point that the subsidy ends.

In some provinces, however, the turning point is so low that many low-income families are ineligible for full subsidy and may receive very low partial subsidies. In 1987, the turning point for a two-parent family with two children was $10,044, $13,512, and $15,500 in Newfoundland, British Columbia, and Quebec, respectively.[38] The 1987 poverty line for a family of four was $21,414 in St. John's and $22,532 in Vancouver and Montreal.[39]

While many support systems are in place for very poor individuals and families, these systems do not "catch" many of the near-poor or lower middle-income families. In 1985, the latest year for which data are available, there were 908,000 low-income families of whom more than half (55.3 per cent) were headed by someone in the labour force. That is, there were 502,000 working poor families in Canada.[40]

It is possible that almost seven per cent of Canadian families are being excluded from many programs and services because their low incomes are not low enough to render them eligible. They must often reach the point of desperation before the system is able to respond.

■ Inappropriate Services

Even though some services are available and are relatively well funded, they are still not responding to women's needs. This is because their orientation is framed within traditional sex-role stereotyping which devalues women's worth in society.

Mental health services are a case in point. A study which documented the attitudes of mental health professionals from a variety of disciplines found that these clinicians' judgements reinforced sex role stereotypes.[41] Women described by these therapists as more submissive, less independent, more concerned about appearance, and less rational than men, were considered mentally healthy. The characteristics these professionals selected for a mentally healthy adult, sex unspecified, were found to correspond to their description of the mentally healthy **male**.

Many economically disadvantaged women become emotionally distraught and seek help from mental health agencies. Their problems are interpreted as manifestations of individual weakness rather than as a consequence of socio-economic conditions. Explanations for their behaviour are sought within the individual's psychological make-up and these women are then "treated" with psychotherapy and medication. Very rarely are their difficult life circumstances addressed in any direct way by the mental health professionals from whom they seek help.

Women are especially vulnerable to male violence. Women's groups and organizations have been very vocal in the past two decades in publicly articulating this aspect of women's existence. While more professionals are becoming sensitive to women's experiences in this regard, "for the most part, the practice of mental health professionals continues to locate problems exclusively within the individual woman, to regard her as responsible for her own victimization".[42]

Sexual assault is an extremely common experience for women. Research evidence with respect to rape, for example, reveals that rape is not dependent upon the characteristics of the victim. Yet women who go to traditional therapists to help them deal with the emotional trauma of assault often find that they are blamed for the attack. It is when they go to therapists who hold a feminist perspective that they are able to see the situation as one of sexual violence for which they are not responsible.

Finally, as mentioned previously, males tend to dominate in psychiatry, the most powerful and influential of the mental health professions. Approximately 83 per cent of all psychiatrists are male.[43] One of the consequences of this imbalance is that the male-female power differential in society is replicated in the professional-patient relationship in which women often are expected to be passive and submissive. The result is that the service may simply reinforce rather than help alleviate the original problems for which they sought help.

■ Lack of Control Over Services

Services often remain inappropriate and unresponsive to real-life needs because of the lack of control that consumers, and even providers of service, have over how these should be developed or delivered. Community services funded by government grants have often expanded, contracted, or modified their mandates to fit the funding criteria. The result is that services become tailored to meet the funders' demands rather than the clients' needs.

Ironically, it is often the programs and services funded with public tax dollars that are the least responsive to community input. Decisions regarding the goals and objectives of the service, how monies are to be spent, and how the program is to be delivered, are generally made by the bureaucrats who allocate the public funds.

At an Ottawa meeting in January 1987, representatives of transition homes expressed their concern about the lack of consultation with shelter workers regarding long-range planning and policy development. Despite the

critical role they play in supporting and assisting battered women, their expertise is rarely taken into account.[44] A recently published report on battered women also pointed out that

> . . . [t]he expertise of shelter workers and other women and men working with battered women and their children should be given adequate recognition through improved salaries, better working conditions, and through the general inclusion of these workers in advisory roles and policy-making bodies.[45]

Lack of control is usually associated with large and complex organizational structures. Child welfare agencies, community colleges, hospitals, and government departments develop elaborate rules and procedures to carry out their functions. There tends to be an emphasis upon uniform implementation of policy, explicit goals, and measurable results. One of the unintended consequences of these management techniques is a narrowing of the services provided in order to fit the clearly defined objectives of the organization rather than the diverse needs of the clientele.

It is difficult, for example, for a patient to influence the type of services provided by a hospital; few hospitals actively seek such patient input. It is hard for a prospective student to request scheduling changes which are more responsive to her child-care needs. Welfare recipients may not apply for a special needs allowance to which they are entitled because of the fear they may be "cut off" if they "demand" too much.

Even professionals who try to advocate on behalf of clients may find their efforts thwarted by a recalcitrant system. They themselves are often "caught in a bind" between complying with employer requirements and, at the same time, trying to meet community needs. For example, the difficulties that staff may encounter in the mental health field are described by one author in the following way:

> . . . workers in some settings may receive formal or informal directives indicating that policy matters are not their concern; that association of any sort with political parties is forbidden; that anything learned at work is

> confidential (not just client information); that every public address must be submitted for prior written approval; that there will be no contact with the public media; that career advancement will be curtailed if the employee is involved with advocacy groups; and that, internally, service concerns may be discussed only with the immediate supervisor.[46]

In short, large bureaucratic systems expect conformity to certain standards and norms. Dissension and questioning of policies, practices, rules, and procedures are not condoned. These "guidelines for behaviour" help minimize the possibility of conflict between the private interests of employees and their responsibility to the public. At the same time, however, constraints which suppress critiques of the status quo also deny opportunities to bring about an improvement of services.

There is a lack of consumer control of services even in voluntary organizations which are run and controlled by members of the local community. In many agencies, tension arises around the desirable extent of consumer representation on boards of directors. Many self-help groups have sprung up in recent years precisely because of the inability of the consumers of various services to have a greater say in how these services are provided.

Delivery Gaps: Summary

In addition to gaps in the programs themselves, there are gaps in the way in which current programs and services are delivered. The six areas of delivery gap discussed here include: the piecework approach, lack of coordination, the "casualty" orientation, "cracks" in the system, inappropriate services, and lack of control over services. While this description is not all-encompassing, it does provide a fairly comprehensive overview of the key areas of delivery gap — that is, the gap between women's needs and the delivery of services.

Double Gaps

All women experience reality gaps. At some point in our lives, we all come face to face with the fact that the current range of programs and services falls short of meeting our needs. There may be gaps in the programs themselves or in their delivery. Services may be inappropriate or inflexible, insufficient in their supply, or inadequate in terms of the benefits provided.

Certain women, however, experience a "double gap". For these women, the reality gap is exacerbated by the fact that existing programs and services are particularly unsuited or unresponsive to their specific needs. Those who face a double gap include: rural women, aboriginal women, immigrant women, visible minority women, disabled women, and adolescent women.

■ Rural Women

The sheer lack of availability of programs or services in rural areas is one of the major problems experienced by rural women. For example, the isolation of rural women and the lack of shelters for battered women in rural and remote communities is well documented.[47] The need for child-care services is also particularly acute.

Access to health care is another serious problem for rural women. For example, a recent article on farm women which presented a profile of health services in the Huron and Bruce counties of Ontario documented that the mental health needs of the 56,000 residents of Huron are served by one psychiatrist and one agency, the Huron Centre for Children and Youth.[48] This is highly inadequate given the enormous stresses faced by farm families struggling for economic survival. Farm women, in particular, are doubly stressed in that they are greatly overworked, are considerably underpaid, and bear the major responsibility for child care.

Illnesses such as heart disease and cancer are as prevalent in rural communities as they are in urban areas, but rural patients must travel long distances for treatment. There are also hazards unique to farm life, including dangerous machinery, chemicals and gases, and large animals. Although these hazards have resulted in high rates of accidents and deaths on Canadian farms, the availability of treatment and prevention services is minimal when compared with the risks.

A survey of the needs of farm women in Bruce County was undertaken by the Concerned Farm Women group. The survey revealed that mental fatigue, frustration, depression, irritability, and headaches were experienced by the women as a result of their financial stresses. Of those women who went to their doctors for advice, 58 per cent of them received drugs for their "emotional" problem and 25 per cent received both drugs and counselling. Only 17 per cent received just counselling. Many of the women expressed anger that their needs had been addressed through the prescription of drugs.[49]

One of the outcomes of the study was the establishment of a badly needed counselling service in Bruce County to help families cope with the stresses of farm life. A major focus of the service has been the potential threat of violence toward women who often become the victims of physical abuse in highly stressed families.

■ Aboriginal Women

Like rural women, Indian and Inuit women also experience glaring gaps in service. More than half of all aboriginal people live in rural areas of the country but not on farms. In 1981, only four in ten aboriginal people made their homes in urban areas compared with eight in ten other Canadians.[50] Aboriginal people are also less likely to live in large cities — only 24 per cent were in cities with populations greater than 100,000 compared to 52 per cent of non-aboriginal people.[51] Health and social programs and services simply do not exist in many rural and remote parts of the country.

In addition to the availability gap, there is also a problem related to the linguistic and cultural appropriateness of existing programs and services. The current service network has evolved primarily in response to the needs of white, nuclear families. Programs and services have not been designed to take into account aboriginal traditions, the important role of elders in raising children, and the communal values prevalent in aboriginal culture.

In some cases, the dissonance between this culture and traditional services has resulted in irreparable damage to aboriginal women and their families. The most serious problems have arisen with respect to the welfare of children.

During the 1960s in particular, child welfare authorities acting in the "interest" of protecting children from neglect and abuse removed status Indian children from the reserves. These children were placed primarily in non-native foster homes. As a result of the 'sixties "scoop", thousands of aboriginal families were split up and the children torn away from their traditions and culture.[52]

Even today, the numbers of children removed from their families remain high. The latest available data indicate that in 1980-1981, there were approximately 6,000 status Indian children in the care of child welfare authorities. This represents six per cent of status Indian children under the age of 16. By contrast, only one per cent of non-aboriginal children or 75,000 children of the same age were in care in that year.[53] National data with respect to non-status Indian, Metis, and Inuit children in care are unavailable.

Many Indian bands and tribal councils have reacted angrily to what they perceive to be "cultural genocide". They have demanded control of their own services to allow them to provide culturally appropriate family and child welfare services. If supports such as emergency and respite child care had been in place, the need for removing children from their homes might have been significantly reduced.

The availability of such supports is particularly important in aboriginal communities considering the high birth rate for aboriginal women. In 1981, the average number of children for ever-married aboriginal women was 3.8, compared to 2.5 for other women.[54]

Aboriginal women are particularly vulnerable because so many are single parents. The 1981 Census found that the percentage of aboriginal families headed by lone parents was almost double the percentage of non-aboriginal single-parent families. Female lone parents headed 17 per cent of aboriginal families compared with nine per cent of other families.[55]

The program gaps with respect to income security earlier described are especially serious for these lone parents and for aboriginal women in general. Government transfer payments constitute the second largest source of income for aboriginal people.[56] The proportion of their income in the form of benefits such as social assistance and Old Age Security is double that for non-aboriginal people. In short, current programs and services are lacking in their availability, appropriateness, and adequacy.

■ Immigrant Women

Traditional programs and services have not been particularly sensitive to the needs of immigrant women. One of the major gaps for immigrant women who have recently arrived in Canada is that services are rarely provided in languages other than English and French. As a result, many of these women are not aware of the services for which they are theoretically eligible. Even if they are aware, language often acts as a barrier to these services.

Many immigrant women, for example, would qualify for child-care subsidies under the Canada Assistance Plan because their net income falls below the provincial "break-even" point. Yet many do not receive the subsidy because they do not know about the subsidy or have difficulty applying.[57]

In some cases, there are simply no services available to them at all, especially in the mental health field. As a result, many immigrant women have had to establish their own services in order to meet their needs. In London, Ontario, for example, a group of Portugese women who have been battered by their husbands have come together to help each other. Traditional services were unable to provide them with the support or concrete assistance they required such as legal advice or information on financial aid or housing.[58]

Ethnic minority women who have lived in this country for many years may not experience language barriers but still find many services inappropriate or insensitive to their needs. Child-care programs, for example, tend to be "unicultural" in their approach. There is insufficient attention paid to creating learning and play environments that are reflective of various cultural backgrounds.[59]

In a more practical vein, most traditional child-care programs are unable to meet the scheduling needs of immigrant women, many of whom are employed in the manufacturing and service sectors. They are required to be on the job very early in the morning or to work in the evenings or weekends. These women have no choice but to resort to the informal child-care market.

From an economic perspective, a research study prepared for the Royal Commission Report on Equality in Employment (the Abella Report) pointed out that immigrant women suffer marked economic disadvantages. They have "higher rates of unemployment and higher rates of needs for social assistance than the national averages. When employed, they tend to be concentrated in the low-skilled, low-paid, and most vulnerable sectors of the labour market."[60]

Low status in the labour market results in barriers to educational upgrading and skills training because immigrant women are generally ineligible for employer-sponsored opportunities. They rarely have the means to pursue these opportunities at their own expense or on their own time because of low salaries and the demands of their work-related and child-care responsibilities.

Those individuals who cannot function in either English or French are also cut off from opportunities for participating in upgrading, skills training, and adult education programs. Their difficulties in gaining access to these opportunities are exacerbated by the lack of language training for immigrants; this program gap creates a long-term structural barrier toward improving their economic and social conditions.

Another background study conducted for the Abella Report found that even among

> . . . minority members who are well-trained and experienced, skilled workers and professionals have been penalized for lack of 'Canadian' experience or by artificially high requirements for certification or credentials. Those groups that have succeeded in rising close to the norm still find that they may be excluded disproportionately from senior management, executive appointment, and powerful positions.[61]

On June 12, 1987, the Minister Responsible for the Status of Women and the Minister of Employment and Immigration announced adjustments to the Canadian Jobs Strategy (CJS) to assist women who are considered "doubly disadvantaged". Changes are being made to the Job Entry, Job Development, and Skills Shortages components of the CJS to facilitate access to training, particularly by immigrant and aboriginal women.

■ Visible Minority Women

Visible minority women have unique needs which arise from the "double discrimination" they face as a result of their sex and colour or race. They have difficulty finding employment and experience serious problems in relation to income security and adequate housing.

With respect to employment in particular, there is little reliable statistical information available on the labour market situation of visible minorities. There are two reasons for this: the lack of consensus regarding appropriate definitions and the broad range of ethnic and racial groups, some of whom have been in Canada for a long time and others of whom are recent immigrants. Table 2 provides a breakdown of the labour force by sex and ethnic group as of June 1981 (the most recent data available from Statistics Canada at the time of writing).

TABLE 2 LABOUR FORCE IN JUNE 1981, BY GENDER AND BROAD ETHNIC CATEGORIES*

Ethnic Categories	Male	Female	Total**
		(in 000s)	
British Isles	2,867	2,007	4,874
French	1,874	1,237	3,112
Other European	1,642	1,057	2,699
Indo-Pakistani	61	39	100
Indo-Chinese	16	10	26
Japanese	14	10	24
Korean	6	5	11
Chinese	88	68	155
Pacific Islands, including Philippines	20	25	45
Black Origin	39	39	78
Native People	75	48	123
Central/South American	5	6	10
Other	46	23	71
Total Single Origin**	**6,755**	**4,574**	**11,329**
Total Multiple Origin	**400**	**325**	**725**
Total Labour Force**	**7,155**	**4,899**	**12,054**

Source: Canada, Statistics Canada, unpublished data from the 1981 Census.
Notes: * Labour force participants reporting single ethnic origin.
** Totals are independently rounded and do not necessarily equal the sum of individually rounded figures in distributions.

A background study conducted for the Abella Report indicates that, because of the lack of reliable and current national data on the employment of visible minorities, it is very difficult to draw definitive conclusions about their labour market position.[62] Yet studies conducted in certain communities have found that blacks, in particular, are often relegated to the lower end of the occupational scale with resulting low incomes.[63]

Another background study concluded that visible minority women face particularly serious economic disadvantages.[64] They tend to be concentrated in the low-wage and low-skilled occupations. One of the primary reasons for this low status is that discrimination which visible minority women experience in the workplace has effectively limited their choices in the labour market as well as their opportunities for promotion and advancement.

Yet discrimination is only one factor which plays a role in relegating visible minority women to a disadvantaged status in the labour market. There is a lack of appropriate and culturally sensitive employment training, upgrading, and placement programs designed to meet the needs of visible minority women.

These women also face serious problems in finding suitable housing. Mother-led households experience the greatest difficulties. First, their low incomes and insecure employment severely limit their ability to afford suitable housing. One study of female-led households, in general, found that such households must spend more than 50 per cent of their gross monthly income on housing.[65]

Single-parent women, in general, experience discrimination not only because of low incomes but also because they have children. These negative attitudes toward children on the part of landlords make the search for suitable accommodation all the more difficult.[66] Yet the obstacles become almost insurmountable for the visible minority single parent who faces three major barriers: low incomes, anti-family attitudes, and discrimination based on race and colour.

There are few traditional social services which effectively respond to the needs of women who experience a "triple gap". They have had to establish alternative services such as the Coalition in Support of Visible Minority Women in Montreal to supplement inappropriate and unresponsive social services.

Disabled Women

It is only in the past few years that disabled women's issues have begun to be articulated. The Coalition of Provincial Organizations of the Handicapped (COPOH) has made women's issues a priority for policy development.

COPOH's concerns include the fact that disabled women are more likely to be sexually assaulted and to be the victims of violence.[67] As well, the unemployment rate among women with disabilities is 74 per cent. Those in the paid labour force earn 64 per cent of the wages of working women[68] who, in turn, earn only 64.5 per cent of men's wages. Few services address the employment needs of disabled women — both with respect to improving their knowledge and skills as well as changing employer attitudes toward the hiring of disabled women.

There is also a serious lack of independent living services, a major program gap earlier described. In addition, disabled women cannot gain access to most existing programs and services because of a variety of barriers. While there have been significant improvements since the International Year of Disabled Persons in 1981, most services remain totally inaccessible. There are still many buildings with no ramps or elevators; public information is rarely made accessible to hearing or visually impaired persons.

The problem of access is particularly acute in the case of voluntary services which are often located in inaccessible private buildings such as churches or old houses. Voluntary organizations are usually strapped for funds and rarely have extra monies for modifications to their property or purchase of special equipment. The result is that disabled women do not have access to the services available to other members of the community.

There are also groups of disabled individuals who face very specific gaps. Mental health services for deaf people, for example, are practically non-existent. The education and training needs of learning disabled adults have not been adequately addressed.

Disabled women, in general, face multiple problems. Because they are discriminated against in the workplace, they tend to be unemployed and have low incomes. Neither is the traditional female role of mother seen as appropriate for disabled women. In short, there are no culturally valued roles considered acceptable for disabled women. Few of the existing social welfare services have attempted or been able to respond to the unique difficulties experienced by these women.

■ Adolescent Women

Adolescent women are often denied service such as family planning or income assistance because they are "minors" in the eyes of the law. In most provinces, adolescents between the ages of 16 and 18 fall under the jurisdiction of child welfare authorities. Their need for a particular service such as social assistance, family planning and contraception, public housing, or child care is denied on the grounds that they themselves require protection.

Part of the gap for adolescent women stems from the widely held public belief that if certain services were extended to these women, the very availability of these services would cause them to behave in socially undesirable ways; that is, they would run away from home, or there would be an epidemic of babies born to adolescents. The fact is, these problems currently exist. Adolescent women **do** run away from home and **do** become pregnant. Yet traditional services deny these realities or try to "wish them away" as though the problems will disappear if they are not addressed.

Often, adolescent women run away from home because they are seeking refuge from what is for them an intolerable situation. They may be escaping from violent or incestuous family relationships. Yet existing services

try to reunite them with these families or deny them alternatives to their current situation. Adolescent women are generally treated as though they were the perpetrators, rather than the victims, of family problems.

Double Gaps: Summary

All women experience a gap between needs and the programs and services provided to meet these needs. However, certain groups of women experience unique difficulties. While there may be others who face a "double gap", the needs of rural women, aboriginal women, immigrant women, visible minority women, disabled women, and adolescent women remain particularly acute.

ADDRESSING THE PROBLEM

Bridging the Gap

Women's groups and organizations have a major role to play in bridging the reality gap by making programs and services more responsive to our needs. We must stop changing our lives to accommodate the needs of institutions. We must instead force those institutions to be more responsive to our real-life needs. We must become the active "shapers" and "moulders" of these programs and services rather than the passive, unquestioning, and dependent recipients of inappropriate, inadequate, or inflexible services.

Shaping services to be more responsive to our varied needs requires a range of actions to be taken at local, provincial, and national levels. These actions include: articulating need, challenging policies, changing institutions, and becoming more involved in decision-making process.

■ Articulating Need

Women's groups and organizations can act as the catalysts to help women from all walks of life and from all ranges of education and income levels express our needs. Articulation of need is important because it serves to legitimize these needs. It helps us acknowledge and recognize our needs as real and important.

Collective discussion and recognition of need are key steps in the process of translating "private troubles" into "public issues". Finally, articulation of need is essential in identifying the major gaps in existing programs and services. It is also critical in helping to move the social welfare system out of its casualty orientation toward a system which is more responsive to our physical and psychological needs.

There are many avenues for encouraging expression of need in local communities. These include informal meetings in schools, child-care centres, workplaces, shopping centres, churches and synagogues, welfare offices, and town halls. Existing organizations such as women's groups, community associations, and service clubs can be used as vehicles for encouraging such discussions.

Expression of need must also take place at provincial and national levels. There may be local issues that are of concern throughout an entire province, such as retrenchment in the funding of health services, or throughout the country, as in the lack of shelters for battered women.

Once key areas of local, provincial, and national need have been identified, organizations representing women's interests have an important role to play in placing and keeping these issues on the public agenda. In fact, it is precisely **because** of the women's movement that issues of relevance to women have been on the public agenda at all.

Prior to the establishment of the Royal Commission on the Status of Women in 1967, little public attention had been paid to women's needs. The Report on Social Security for Canada (commonly known as the Marsh Report) was the only major document that had explicitly addressed women's issues; it devoted a section to the social security needs of women.[69]

The Report of the Royal Commission on the Status of Women in Canada (1970) was a landmark document in that it was the first public report which clearly addressed and articulated the needs of Canadian women in a range of areas including pensions and child care. It was upon the recommendation of this Commission that the Canadian Advisory Council on the Status of Women (CACSW) was established.

Since its inception, the CACSW has helped identify issues of concern to women and advocate programs and services to meet women's needs. For example, the Council's 1980 report on battered women represented the first attempt in this country to put the issue of battered women on the public agenda.[70] The CACSW has since published a second report (1987), pressed for improved awareness of this problem, and lobbied for a network of services such as transition homes to provide protection to battered women and their children.

The National Action Committee on the Status of Women (NAC) was established in the early 1970s. It acted as a coordinating body to channel the views of its member organizations (voluntary women's groups across the country) to the federal government departments concerned with the implementation of the Royal Commission's recommendations. NAC evolved from the Committee for the Equality of Women in Canada, a group which had pressed for the establishment of a Royal Commission. NAC continues to play a leading role in articulating women's needs and identifying gaps in current programs and services such as pensions and child care.

There have been other reports on women's needs since the publication of the Royal Commission's landmark document. Two of the most important have been the Report of the Royal Commission on Equality in Employment[71],

which articulated women's employment-related needs and the Report of the Task Force on Child Care (the Cooke Report)[72], which identified the range of needs for high-quality child-care services. Women's groups and associations at local, provincial, and national levels have been active in ensuring that these issues and others, such as a homemakers' pension and violence against women, are the subject of public attention and debate.

In addition to its influence at the social policy level, the women's movement has also played a key role in promoting personal awareness. It is because of the movement that many women feel confident about making changes in our interpersonal relationships. We are better able to express our needs and our expectations with respect to men assuming more responsibility for raising children, caring for elderly parents, and managing a household. In short, articulation of need must be expressed at both interpersonal and societal levels.

■ Challenging Policies

Women must remain vigilant. We must identify any areas of policy or practice that are inflexible or inappropriate to our needs and, where such policies or practices exist, these should be challenged.

An example of a questionable policy is the so-called "spouse-in-the-house" rule which is found in several provincial social assistance regulations. This rule pertains to single mothers living with a man. The rule assumes that by virtue of having a relationship with a man, a women is automatically dependent upon him for economic support and that he is assuming financial responsibility for her children.

When women's groups became aware of this practice, they took action. For example, in 1984, an Ottawa-based organization called Women for Justice lodged a complaint with the Ontario Human Rights Commission. The groups argued that regulations under the *Family Benefits Act* discriminate against women on the basis of sex and marital status by forcing them to be financially dependent upon men and by depriving them of equal access to goods

and services. The province of Ontario changed these provisions in November 1987 so that assessment of need is no longer based on sexual and marital criteria, but upon legal support obligations.

There are other instances in which vigilance and challenge pay off even when the odds seem impossible. Eight years ago, seven Montreal women decided to challenge Canadian National (CN) Rail because the company had refused to hire them as blue-collar workers. The women were backed by a local lobby group, Action Travail des Femmes, which assists women in finding non-traditional jobs. The dispute ended at the Supreme Court of Canada, which found CN guilty of discrimination and determined that, in the future, when CN hires employees for blue-collar jobs, one in four employees must be a woman.

Sometimes court challenges are necessary for calling into question practices that are unfair to women. The Court Challenges Program funded by Secretary of State supports the costs of litigation in selected test cases related to language and equality issues stemming from Canada's constitutional provisions. The Program has approved funding for several cases in which federal government programs and services are being challenged because they are inappropriate to the needs of women.

One group currently receiving funding is "Single and Divorced Speak Out", which was organized in 1984 to bring attention to the poverty suffered by single and divorced elderly women. The association objects, in particular, to the Spousal Allowance provided under the *Old Age Security Act*. This legislation make special provision for widows and widowers between the ages of 60 and 64 who are in financial need. At age 65, the Allowance ceases because recipients become eligible for Old Age Security benefits and, where necessary, the Guaranteed Income Supplement.

"Single and Divorced Speak Out" contends that eligibility rules for financial assistance to the near-elderly should be provided on the basis of financial need and not according to marital status. They maintain that all individuals without a partner, whether because of death, divorce or never having

married, are "single". No distinction should be made on the basis of why a person is single when determining eligibility for an income security program.

In short, there is a gap in the current program which virtually excludes many potentially eligible women. The current practice does not meet real-life needs and will be challenged in the courts.

■ Changing Institutions

Challenging policies and practices of individuals must be supplemented by activities which encourage various institutions such as workplaces, social service agencies, school boards, and government departments to accommodate the needs of women.

■ *Workplaces*

Women represent an increasingly important segment of the labour force. Yet workplaces have done little to respond to the family-related needs of female (and male) employees. While some employers permit personal leave for family responsibilities, only a minority provides this as a paid benefit. Taking a child or parent for medical treatment or attending an occasional school function are carried out at the employee's expense. Few workplaces allow paid maternity leave beyond the legal requirements.

Table 3 presents a percentage breakdown of employers in Canada who reported flexible work arrangements for some or all employees in a recent national survey.

Some interesting programs have been implemented in Canada that can serve as models for future efforts in this field. Lavalin Inc., the Canadian-based international engineering firm, has set up a child-care facility based in a location separate from but close to the company offices. The centre also provides licensed infant care which, as discussed earlier, is a "rare commodity" in relation to the demand for this service.

TABLE 3 EMPLOYERS REPORTING FLEXIBLE WORK ARRANGEMENTS FOR SOME OR ALL EMPLOYEES*

Arrangement	Private Sector Corporations	Hospitals (in percentages)	Government and Crown Corporations
Leave for family responsibilities with or without pay reduction	87.5	90.0	95.4
Leave for family responsibilites with no pay reduction	32.7	33.9	59.0
Flexible work schedule	39.6	24.8	58.4
Part-time work	35.2	80.9	50.0
Job-sharing	10.1	33.6	47.7
Work-at-home	6.9	1.3	9.3

Source: Canada, House of Commons, Special Committee on Child Care, *Sharing the Responsibility* (Ottawa: Queen's Printer for Canada, 1987).

Note: * Number of employers surveyed: 144 private sector companies, 58 hospitals, and 44 government agencies and Crown corporations.

Women's groups, employee associations, and trade unions must make their needs known to employers and must press for accommodation of these needs. This articulation should take place at local, provincial, and national levels so that relevant business organizations such as chambers of commerce, the Canadian Manufacturers Association, the Retail Council of Canada, the Canadian Federation of Independent Business, and the Business Council on National Issues, are made aware of the needs of female employees.

■ *Social Service Agencies*

Social service agencies generally function on a "professional-client" basis in which the professional is assumed to be all-knowing and the client is helpless and dependent. Social service clients must be made aware that they need not be helpless recipients but can instead be articulate and informed consumers. After all, the agency could not survive if clients were not there to "consume" the service.

Clients of social service agencies can be "empowered" through the provision of information about their rights and through consciousness-raising which women's groups and organizations have been able to carry out so effectively. "Empowerment" also takes place by enhancing individual self-esteem; by making women aware of our needs and of our right to request more responsive services; by teaching women about methods of influencing boards of directors, fundraising bodies, and government departments; and by encouraging women to become directly involved in decision-making processes.

When services provided by traditional agencies are non-existent or inappropriate, women have sometimes set up alternatives by forming collectives or self-help groups to meet our needs. One example is the single-parent associations throughout the country. They are comprised primarily of women who need more and different types of services than traditional agencies can provide, including opportunities for socialization, ongoing support, and concrete assistance.

Several mothers in Summerside, Prince Edward Island, organized a "Hurray for Moms" group to provide mothers with a "break" and a chance to share their concerns about parenting with other women.

The Coalition in Support of Visible Minority Women, located in Montreal, serves as a forum to help identify and articulate the needs of visible minority women. The Coalition also links individuals to training programs and other appropriate services.

A group of women in Wellington County, Ontario, formed an advisory committee to discuss the problems faced by families living in a rural area. They began by publishing a community information directory and by opening an information and referral office. Because of the great demand for child care, the women worked on the development of a registry which lists the services of in-home caregivers. Names on this list are checked for any record of child abuse.

A female physician practising at the Halifax Infirmary in Nova Scotia recruited several of her female colleagues to serve on a roster as specialists in the examination of sexually assaulted women.[73] These physicians, on their own time, have participated in special training programs to learn how to examine, diagnose, and treat the victims of sexual assault in a sensitive and appropriate manner.

■ *School Boards*

School boards have the potential to play a much larger role in communities than they currently do. They are in a position to provide the resources and facilities to meet many of our needs. For example, school boards can offer more training courses for women that are relevant to local labour demands.

School boards can also help bridge the child-care gap by facilitating the establishment of school-age child-care programs. Quebec's Ministry of Education actively supports the development of licensed child-care spaces in schools. It makes available a one-time start-up grant of $3,000 for capital expenses as well as yearly per capita operating grants.[74]

Boards of education can also provide an important mental health service for mothers and a socialization opportunity for preschoolers by allowing groups of mothers to set up drop-in or parenting resource centres on school premises. Women must work collectively to bring about the change in orientation among school trustees that will then allow the development of services to accommodate our needs.

■ *Government Departments*

Perhaps the most difficult system to challenge is the government department. Yet the determination, hard work, and tenacity of one organization shows that this can, in fact, be done.

The Community Living Society was spearheaded by the Woodlands Parents' Group, formed in 1976 by parents whose mentally handicapped children were residents of the Woodlands institution in British Columbia. In talking with

each other, these parents realized that they shared an important experience. Their hopes and dreams for their children's future had been shattered by traditional services that minimized the abilities and potential of their disabled children and limited the expectations for any normal growth opportunities.

These parents helped each other "reclaim the vision" of their children as individuals who were capable of functioning within the community. They quickly learned, however, that this vision could be realized only if there were a system of services in place which responded to the needs of the individual and surrounded that person with a network of supports focussing upon the individual's strengths.

The Woodlands Parents' Group developed a statement of beliefs and values, from which a set of principles naturally evolved. These principles included a focus upon the individual. They challenged traditional methods of funding and insisted that any public dollars provided for services should be attached to individuals according to their needs and abilities. The Community Living Society was established to put these principles into practice. It has established an innovative approach to the delivery of social services: a "brokerage" system in which "brokers" help families find and negotiate service contracts on behalf of the disabled individual.

The Society has, in effect, developed a system of funding based primarily upon "demand" (giving money directly to individuals) rather than upon "supply" (giving money to services). There are some dangers inherent in this model; if money is pulled out of the supply side of the equation, then services will suffer. Yet the existing services had been so unresponsive to the real-life needs of these individuals that they saw no other choice but to challenge the system and bring about a radical change in the funding and delivery of the services they required.

■ Becoming More Involved in Decision-making Processes

The reality gap will be narrowed only when women become more involved in the processes which govern where and how funds for programs and services are spent. We must stop seeing ourselves as the passive recipients of decisions that others make about and for us. We must begin to view ourselves as the active formulators and shapers of these decisions. Again, a multifaceted approach is required.

Women's groups and organizations must encourage more of us to seek public office if we are to have our interests represented directly in the political sphere. We must seek greater input on advisory boards and councils. We must seek positions as trustees of school boards and elected members of city councils, provincial legislatures, and the federal parliament. The direct involvement is necessary if we are to have an impact upon how decisions are made.

To date, public decision-making processes have been dominated by men whose life experiences are very different from our own. Men do not experience our reality. They do not face our unique stresses. They have not had to assume a secondary economic role. They have not had to deny their own needs. Their funding priorities in the political arena reflect this different reality.

We must inform ourselves as to where decisions are made. We must find out, for example, who determines the nature of the services that a local family agency will provide — the board of directors, the professional staff, or the funding body? How can the relevant group be influenced?

It may not be easy, but it is possible and appropriate for consumers of a service to influence boards of directors. Such influence can be effected through direct involvement such as seeking a position on the board or indirect involvement by articulating to the board the various areas of concern with agency service.

In addition to direct involvement, we must indirectly implicate ourselves in decision-making. We must collectively educate ourselves about political processes and acquire lobbying skills to make our needs known to local, provincial, and national levels of government; to special commissions and legislative or parliamentary committees; and to relevant bodies such as voluntary organizations and local women's groups. We must also press political parties to address the concerns that are of relevance to women and to help us challenge the areas of gap that we identify.

ELIMINATING THE GAP?

It is possible that a reality gap will always exist. Our needs are constantly changing. New needs are emerging. There will likely always be a lag from the time that a need is clearly articulated until an appropriate program or service is in place to respond to that need.

If, however, we remain vigilant — if we continue to identify and clearly define the areas of program, delivery, and double gap — then we can work methodically toward closing those gaps. A gap between needs and programs or services may always exist, but its distance need not be so great. It is up to women to build the bridges that will narrow — and perhaps one day even close — the reality gap.

NOTES

1. Anita F. Heller, *Health and Home: Women as Health Guardians* (Ottawa: Canadian Advisory Council on the Status of Women, March 1986), p. 1.

2. Canada, House of Commons, Special Committee on Child Care, *Sharing the Responsibility* (Ottawa: Queen's Printer for Canada, 1987), p. 8.

3. Canada, Statistics Canada, *Earnings of Men and Women 1986* (Ottawa: 1987), catalogue no. 13-217.

4. *Ibid.*, p. 9.

5. Abraham Maslow, *Motivation and Personality* (New York: Harper, 1954).

6. Linda MacLeod, *Battered But Not Beaten . . . Preventing Wife Battering in Canada* (Ottawa: Canadian Advisory Council on the Status of Women, 1987), p. 3.

7. Harold L. Wilensky and Charles N. Lebeaux, *Industrial Society and Social Welfare* (New York: Russell Sage Foundation, 1958).

8. *Ibid.*

9. Dennis Guest, *The Emergence of Social Security in Canada* (Vancouver: University of British Columbia Press, 1980), p. 11.

10. Canadian Mental Health Association, *Women and Mental Health in Canada: Strategies for Change* (Toronto: April 1987), p. 48.

11. National Council of Welfare, *Progress Against Poverty* (Ottawa: April 1987), p. 3.

12. Canada, Health and Welfare Canada, *Canada Pension Plan: Statistical Bulletin Statistique*, vol. 18, no. 4 (December 1986), Table 16, p. 16.

13. *Ibid.*, Tables 27 and 28, pp. 27-28.

14. Information provided by Health and Welfare Canada.

15. National Council of Welfare, *Welfare in Canada: The Tangled Safety Net* (Ottawa: November 1987), Table 5, pp. 65-72.

16. Edmonton Social Planning Council, *Surviving on Welfare — A No-Frills Flight* (Edmonton: March 1986).

17. National Council of Welfare, *Welfare in Canada: The Tangled Safety Net.*

18. *Ibid.*, Table 1, p. 8.

19. Canada, Health and Welfare Canada, *Status of Day Care in Canada* (Ottawa: 1986).

20. *Ibid.*

21. *Ibid.*

22. Canada, House of Commons, Special Committee on Child Care, *Sharing the Responsibility*, p. 46.

23. *Ibid.*, p. 155.

24. Concerns with respect to informal, unlicensed care were raised in many of the submissions made to the Parliamentary Committee on Child Care during its public hearings held between April and June 1986.

25. Canada, Health and Welfare Canada, *Independent Living: Directions for Action* (Ottawa: Canadian Organizing Committee for 1981), p. 8.

26. Canada, Secretary of State, *Profile of Disabled Persons in Canada* (Ottawa: 1986), p. 8.

27. *Ibid.*, p. 13.

28. *Ibid.*, p. 12.

29. Quote taken from film entitled *And After Tomorrow*, available from Health and Welfare Canada.

30. The Family and Child Health Unit of Health and Welfare Canada organized an Intragovernmental Consultation on the Family, in Ottawa on July 8 and 9, 1986.

31. See also: Canada, Health and Welfare Canada, *The Active Health Report — Perspectives on Canada's Health Promotion Survey* (Ottawa: April 1987).

32. MacLeod, *Battered But Not Beaten . . . Preventing Wife Battering in Canada*, p. 31.

33. *Ibid.*

34. *Ibid.*, p. 33.

35. *Ibid.*, p. 34.

36. MaryAnn McLaughlin, *Homelessness in Canada: The Report of the National Inquiry* (Ottawa: Canadian Council on Social Development, Sept. 14, 1987), Table 2, p. 4.

37. *Ibid.*

38. Canada, House of Commons, Special Committee on Child Care, *Sharing the Responsibility*, Table 2.6, p. 29.

39. National Council of Welfare, *1987 Poverty Lines* (Ottawa: March 1987), Table 1, p. 9.

40. Information provided by the National Council of Welfare.

41. Canadian Mental Health Association, *Women and Mental Health in Canada: Strategies for Change*, p. 49.

42. *Ibid.*, p. 62.

43. *Ibid.*, p. 66.

44. Canadian Council on Social Development, *Overview*, pp. 2 and 8.

45. MacLeod, *Battered But Not Beaten . . . Preventing Wife Battering in Canada*, p. 117.

46. Jean L. Pettifor, "Guest Editorial: Making Systems Work for People", *Canada's Mental Health*, vol. 34, no. 1 (March 1986), p. 3.

47. MacLeod, *Battered But Not Beaten . . . Preventing Wife Battering in Canada*, pp. 22-24.

48. Susan Hundertmark, "Rural Feminism", *Healthsharing* (winter 1985), p. 14.

49. *Ibid.*, p. 16.

50. Canada, Statistics Canada, *Canada's Native People* (Ottawa: 1984), p. 2.

51. *Ibid.*, p. 2.

52. Canada, Indian and Northern Affairs Canada, *Indian Social Welfare* (Ottawa: 1982).

53. Canada, House of Commons, Special Committee on Child Care, *Sharing the Responsibility*, p. 68.

54. Canada, Statistics Canada, *Canada's Native People*, p. 5.

55. *Ibid.*, p. 21.

56. *Ibid.*, p. 18.

57. Karen R. Mock, *Child Care Needs of Cultural Minorities*, report prepared for the House of Commons Special Committee on Child Care (Ottawa: Queen's Printer for Canada, 1986), p. 17.

58. This group was discussed in a workshop on health promotion surveys at the 78th Annual Conference of the Canadian Public Health Association held in Halifax on June 22-25, 1987.

59. Mock, *Child Care Needs of Cultural Minorities.*

60. Lin Buckland, "Education and Training: Equal Opportunities or Barriers to Employment?", in *Research Studies of the Commission on Equality in Employment* (Ottawa: April 1985), p. 149.

61. D. Rhys Phillips, "Equity in the Labour Market: The Potential of Affirmative Action", in *Research Studies of the Commission on Equality in Employment* (Ottawa: April 1985), p. 59.

62. *Ibid.*, p. 59.

63. *Ibid.*

64. Buckland, "Education and Training: Equal Opportunities or Barriers to Employment?", p. 149.

65. Diane Morissette, *Housing for Canadian Women: An Everyday Concern* (Ottawa: Canadian Advisory Council on the Status of Women, 1987), p. 8.

66. *Ibid.*, p. 9.

67. Coalition of Provincial Organizations of the Handicapped, *Disabled Women's Issues: A COPOH Discussion Paper* (Winnipeg: n.d.), p. 1.

68. *Ibid.*

69. Guest, *The Emergence of Social Security in Canada*, p. 116.

70. MacLeod, *Wife Battering in Canada . . . The Vicious Circle* (Ottawa: Canadian Advisory Council on the Status of Women, 1980).

71. Canada, Royal Commission on Equality in Employment, *Report of the Royal Commission on Equality in Employment* (Ottawa: 1984).

72. Canada, Task Force on Child Care, *Report of the Task Force on Child Care* (Ottawa: Status of Women Canada, 1986).

73. The author spoke to Dr. Fionnella Crombie about her initiative in the diagnosis and treatment of sexual assault.

74. Canada, House of Commons, Special Committee on Child Care, *Sharing the Responsibility*, p. 47.

SELECTED BIBLIOGRAPHY

Abzug, Bella. *Gender Gap*. Boston: Houghton Mifflin, 1984.

Armitage, Andrew. *Social Welfare in Canada: Ideals and Realities*. Toronto: McClelland and Stewart, 1975.

Buckland, Lin. "Education and Training: Equal Opportunities or Barriers to Employment?". In *Research Studies of the Commission on Equality in Employment*. Ottawa: April 1985, pp. 131-156.

Canada. Health and Welfare Canada. *Canada Pension Plan: Statistical Bulletin Statistique*, vol. 18, no. 4, December 1986.

_____. *Independent Living: Directions for Action*. Ottawa: Canadian Organizing Committee for 1981, 1981.

_____. *Profiles on Home Care: Home Support Programs*. Ottawa: 1985.

_____. *Status of Day Care in Canada*. Ottawa: 1986.

_____. *The Active Health Report — Perspectives on Canada's Health Promotion Survey*. Ottawa: April 1987.

Canada. House of Commons. Special Committee on Child Care. *Sharing the Responsibility*. Ottawa: Queen's Printer for Canada, 1987.

Canada. Indian and Northern Affairs Canada. *Indian Social Welfare*. Ottawa: 1982.

Canada. Royal Commission on Equality in Employment. *Report of the Royal Commission on Equality in Employment*. Ottawa: 1984.

Canada. Secretary of State. *Profile of Disabled Persons in Canada*. Ottawa: 1986.

Canada. Statistics Canada. *Canada's Immigrants*. Ottawa: 1984.

_____. *Canada's Native People*. Ottawa: 1984.

_____. *Earnings of Men and Women*. Ottawa: 1985, catalogue no. 13-217.

Canadian Advisory Council on the Status of Women. *Women and Pensions: Women in Poverty*. Brief to the Parliamentary Task Force on Pension Reform. Ottawa: May 1983.

Canadian Council on Social Development. *Overview*: vol. 4, no. 3. Ottawa: spring/summer 1987.

Canadian Mental Health Association. *Women and Mental Health in Canada: Strategies for Change*. Toronto: April 1987.

Coalition of Provincial Organizations of the Handicapped. *Disabled Women's Issues: A COPOH Discussion Paper*. Winnipeg: n.d.

De Koninck, Maria; Francine Sailiant; and Lise Dunnigan. *Essai sur la Santé des Femmes*. Quebec: Conseil du statut de la femme, 1983.

Dobell, A. Rod and S.H. Mansbridge. *The Social Policy Process in Canada*. Ottawa: Institute for Research on Public Policy, 1986.

Edmonton Social Planning Council. *Surviving on Welfare — A No-Frills Flight*. Edmonton: March 1986.

Estable, Alma. *Immigrant Women in Canada: Current Issues*. Ottawa: Canadian Advisory Council on the Status of Women, March 1986.

Goering, Paula and Joy Rogers. "A Model for Planning Interagency Coordination". *Canada's Mental Health*, vol. 34, no. 1, March 1986, pp. 5-8.

Gottlieb, Naomi, ed. *Alternative Social Services for Women*. New York: Columbia University Press, 1980.

Grindstaff, Carl F. *Adolescent Marriage and Childbearing: The Long-Term Economic Outcome, Canada in the 1980's*. London: University of Western Ontario, July 1986.

Guest, Dennis. *The Emergence of Social Security in Canada*. Vancouver: University of British Columbia Press, 1980.

Heller, Anita F. *Health and Home: Women as Health Guardians*. Ottawa: Canadian Advisory Council on the Status of Women, 1987.

Hewlett, Sylvia Ann. *A Lesser Life*. New York: William Morrow and Co., 1986.

Hundertmark, Susan. "Rural Feminism". *Healthsharing*, winter 1985, pp. 14-17.

MacLeod, Linda. *Battered But Not Beaten . . . Preventing Wife Battering in Canada*. Ottawa: Canadian Advisory Council on the Status of Women, 1987.

_____. *Wife Battering in Canada: The Vicious Circle*. Ottawa: Canadian Advisory Council on the Status of Women, 1980.

Maslow, Abraham. *Motivation and Personality*. New York: Harper, 1954.

Mock, Karen. *Child Care Needs of Cultural Minorities*. Report prepared for the Special Committee on Child Care. Ottawa: Queen's Printer for Canada, 1986.

Morissette, Diane. *Housing for Canadian Women: An Everyday Concern*. Ottawa: Canadian Advisory Council on the Status of Women, March 1987.

National Council of Welfare. *1987 Poverty Lines*. Ottawa: March 1987.

_____. *Progress Against Poverty*. Revised edition. Ottawa: April 1987.

_____. *Welfare in Canada: The Tangled Safety Net*. Ottawa: November 1987.

National Symposium on Women and the Economy. March 17-18, 1986. Ottawa: Canadian Advisory Council on the Status of Women, 1986.

Pettifor, Jean L. "Guest Editorial: Making Systems Work for People". *Canada's Mental Health*. vol. 34, no. 1, March 1986, pp. 2-4.

Phillips, D. Rhys. "Equity in the Labour Market: The Potential of Affirmative Action". In *Research Studies of the Commission on Equality in Employment*. Ottawa: April 1985, pp. 49-111.

Spiegel, Allen D. *Home Healthcare*. Owings Mills, Md.: National Health Publishing, 1983.

Stewart, Jane E. *Home Health Care*. St. Louis: The C.V. Mosby Company, 1979.

Turner, Joanne C. and Francis J. Turner. *Canadian Social Welfare*. Don Mills: Collier Macmillan Canada, 1981.

Wilensky, Harold L. and Charles N. Lebeaux. *Industrial Society and Social Welfare*. New York: Russell Sage Foundation, 1958.

Wilson, Elizabeth. "Feminism and Social Policy". In *Feminism and Social Policy*. Ed. Martin Loney, David Boswell, and John Clarke. Milton Keynes, England: Open University Press, 1983.

The Canadian Advisory Council on the Status of Women (CACSW) was established in 1973 as an independent organization funded by the federal government. The Council's mandate is to advise the government and inform the public on matters of concern to women.

The CACSW produces in-depth research on a wide variety of issues affecting women and publishes these findings as books, booklets, background papers, briefs and fact sheets.

All publications are available free of charge.

NATIONAL OFFICE
110 O'Connor Street,
9th floor,
Box 1541,
Station B,
Ottawa, Ontario
K1P 5R5
(613) 992-4976

REGIONAL OFFICES
2021 Union Avenue,
Suite 875
Montreal, Quebec
H3A 2S9
(514) 283-3123

220-4th Avenue S.E.,
Suite 270,
Box 1390,
Station M,
Calgary, Alberta
T2P 2L6
(403) 292-6668

Le Conseil consultatif canadien sur la situation de la femme (CCCSF), créé en 1973, est un organisme indépendant financé par le gouvernement fédéral. Il a pour mandat de conseiller le gouvernement et d'informer le public sur les questions qui préoccupent les femmes.

Le CCCSF mène des recherches approfondies sur un éventail de sujets liés à la condition féminine et en assure la publication sous forme de livres, brochures, documents de référence, mémoires et feuillets documentaires.

Toutes les publications sont offertes gratuitement dans les deux langues officielles.

BUREAU CENTRAL
110, rue O'Connor
9e étage
C.P. 1541, succursale B
Ottawa (Ontario)
K1P 5R5
(613) 992-4976

BUREAUX RÉGIONAUX
2021, avenue Union
pièce 875
Montréal (Québec)
H3A 2S9
(514) 283-3123

220, 4ième avenue S.E.
pièce 270
C.P. 1390, succursale M
Calgary (Alberta)
T2P 2L6
(403) 292-6668

Canadian Advisory Council on the Status of Women
Conseil consultatif canadien sur la situation de la femme

REALITY GAP
1988 9E